Opening Statement of the Honorable Joe Pitts
Subcommittee on Health
Hearing on "Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare's Benefit Design"
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Nearly 50 million seniors rely on the Medicare program for their health care. It is important for us to understand Medicare's current benefit structure and look at ways to modernize it to better serve beneficiaries and protect them from catastrophic costs.

When it was created in 1965, Medicare's benefit design was modeled on private insurance products available at the time.

However, while the private insurance market has undergone dramatic changes in the last half century, Medicare's traditional benefit structure has remained essentially unchanged.

Unlike most private insurance today, which has a single deductible for all medical services, Medicare has separate deductibles for Part A, hospital services, and Part B, physician and outpatient services.

While the Part A deductible is rather high – $1,156 in 2012, the Part B deductible is relatively low – $140 in 2012.

Medicare fee-for-service (FFS) also has a complex and sometimes confusing copayment structure.

In addition to the Part A deductible, beneficiaries also pay daily copayments for stays at hospitals and skilled nursing facilities. Depending on how many hospital stays a senior incurs in a year, he or she may owe more than one hospital deductible for a year.

In addition to the Part B deductible, beneficiaries also pay a monthly Part B premium, and generally pay 20 percent of most charges for outpatient and physician services.

As Medicare's current benefit structure has no cap on how much out-of-pocket spending a beneficiary can incur, seniors are left open to considerable financial risk and uncertainty. They don't know what they will have to pay when they go in for a procedure or test, and ultimately this uncertainty threatens every senior with the potential of medical bankruptcy.

Due to this financial uncertainty – and the lack of comprehensive coverage in FFS – almost 90 percent of beneficiaries purchase or receive supplemental insurance.

Everything about our health care system has changed dramatically since the 1960s as health care has become more and more complex.

The models and standards of care, tests, treatments, drugs, and medical breakthroughs that we enjoy today were unknown when Medicare was enacted.

In 1965, insurance protected us against hospital costs from conditions that were most likely fatal – heart disease, cancer, and stroke. Today, we use insurance to help manage chronic illnesses and treat diseases, allowing beneficiaries to live for decades and to stay in home and community settings for much longer.

The only part of our health care system that has not evolved since Medicare's inception is Medicare's fee-for-service benefit design itself.

We don't give our seniors 1960s medical care – in many cases that would be considered malpractice today – so why do we continue to give them a 1960s insurance product?

We have an obligation to modernize Medicare and standardize its cost-sharing structure. We should have a single deductible for Parts A and B, and we should streamline benefits so that fewer seniors will have to purchase supplemental coverage with money from their own pocket.

We should institute a catastrophic cap on out-of-pocket spending to protect seniors from the threat of medical bankruptcy.

And with Medicare's unsustainable financial footing – according to its Trustees, Medicare will be insolvent by 2024, and as soon as 2017 – we need to expand means-testing for higher-income beneficiaries, in order to protect the most vulnerable seniors.

Let's bring Medicare into the 21st century.

I'd like to thank MedPAC's chairman, Glenn Hackbarth, for agreeing to testify today. In recent years, MedPAC has made many recommendations on how to improve the Medicare program, and we are eager to hear about some of them.

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